Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COLUMBIA RIO GRANDE REGIONAL
HOSPITAL
C/O DAVIS FULLER JACKSON KEENE
11044 RESEARCH BLVD STE A-425
AUSTIN TX 78759

Respondent Name

LUMBERMENS MUTUAL CASUALTY CO

Carrier's Austin Representative Box

Box Number 21

MFDR Tracking Number

M4-98-A996-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All services and treatment provided were customary, reasonable and necessary for the treatment of said injury."

Amount in Dispute: $4767.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that carrier paid 2,213.64 for dates of service 9-25-27-97, which it considers to be fair and reasonable. Amount billed by hospital is unreasonable." "In accordance with Rule 133.305(a) the above noted hospital failed to dispute charges within one calendar year after the dates of service dispute." "In accordance with Rule 133.305(a) carrier was not notified by certified mail by the hospital or their representative of the charges being disputed."

Response Submitted by: Kemper Insurance, P.O. Box 749010, Dallas, TX 75374-9010

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 25, 1997 through September 27, 1997	Inpatient Hospital Services	$4767.44	$22.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the

procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. This request for medical fee dispute resolution was received by the Division on April 20, 1998.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 907-Texas required bill identification.
   - 992-Refer to the units column and the network contract to determine the per diem rate.
   - 938-This hospital per-diem fee schedule has been revierwed in accordance with the Texas Worker's Compensation Commission fee schedule 134.400.
   - 999-Reviewed charges.
   - 939-The services have been reviewed in accordance with Texas Worker's Compensation Commission hospital in-patient fee schedule 134.400.
   - 369-This service has been reviewed per the adjustor's request.
   - C-No code description given.
   - F-No code description given.

Findings

1. The respondent denied disputed services with reason code "C". A review of the explanation of benefits indicates that a contractual reduction of $22.36 was taken. No documentation was found to support a contractual agreement between the parties to this dispute. This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
3. 28 Texas Administrative Code §134.401(b)(1)(B), states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   A review of the submitted medical bill and itemized statement, indicate that the requestor billed for two (2) inpatient surgical day; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).
4. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."
5. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore, 2 days multiplied by $1,118.00 = $2,236.00.

   A review of the submitted explanation of benefits supports reimbursement of $2,213.64 was made for the inpatient surgical services. The difference between the per diem rate of $2,236.00 and amount paid of $2,213.64 is $22.36.

   The requestor supported position that additional reimbursement of $22.36 is due for inpatient services.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement of $22.36 is due the requestor. As a result, the amount ordered is $22.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $22.36 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	12/15/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.